Report of the Secretary of Health and Human Resources

A Plan for Improving Services and Containing Costs in the Treatment and Care of Children Under the Comprehensive Services act for At-Risk Youth and Families

October 15, 2002

Introduction

In 2002, the Virginia General Assembly passed budget language directing the Secretary of Health and Human Resources to develop and promptly implement a plan for improving services and containing costs in the treatment and care of children served through the Comprehensive Services Act (CSA). With the passage of CSA in 1992, the General Assembly altered the administrative and funding systems for providing services to at-risk youth and their families. Specifically, eight funding streams from five state agencies were combined to finance the program. The overarching goal of the program was to promote the treatment of emotionally disturbed children in the least restrictive environment through interagency collaboration at the both the State and local level.

This General Assembly's request for an action plan was prompted largely by concerns associated with the total general fund cost of the program (over $194 million in fiscal year 01), and the average rate at which these costs have been increasing (approximately 10 percent per year). In addition, while it is widely recognized that a number of the initial goals established for CSA have been realized, it has become equally apparent that problems exist with both the State and local management of the program. Accordingly, the budget language passed by the 2002 Virginia General Assembly directed the Secretary of Health and Human Resources to establish a plan that addresses the following issues:

- methods for evaluating and monitoring the quality, appropriateness, and outcomes of care;
- strategies for increasing federal reimbursements for the program;
- assessment and development of negotiated statewide contracts for services purchased by state and local agencies;
- revised allocation methodologies, reimbursement procedures, and cost-sharing formulas for localities;
- coordinated collection of information among state agencies;
- a review of the program's organization and management structure; and
- projections of caseloads, service needs, and costs.

By October 15, 2002, the Secretary is required to submit to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees all recommendations from this Action Plan that impact funding or require statutory revisions.

To develop this plan, the Secretary appointed a Steering Committee consisting of legislators, public and private stakeholders, and state and local partners. From this Committee, separate task groups were assembled and assigned the issues that provide the framework of the Action Plan. Each group examined the relevant CSA policies for their issue area and made recommendations to the Steering Committee for future action.

Appendix A details the Steering Committee's blueprint for action to reform key aspects of the program. As shown, some of the recommendations offered by the committee have been categorized as "near term" with a high priority status. These are essentially those recommendations that the Committee believes should be given immediate consideration by the Governor and the General Assembly. Some of these recommendations are designed to more closely match local allocations for CSA to actual program needs. Others focus on the organization and management of CSA. Also, as a means of defraying the general fund cost of the program, the Steering Committee has recommended expanding the use and scope of Medicaid coverage in CSA.

These and other near-term recommendations are discussed in more detail in the body of this Action Plan. This plan also discusses the longer-term recommendations that the Steering Committee believes require greater study before they can be implemented.

The Revision of Allocation Methodologies, Reimbursement Procedures, and Cost Sharing Formulas for Localities

Statement of the Problem

In CSA, each locality receives an initial base allocation that has been found to account for only 55 percent of annualized costs. Additional funds are available through a supplemental funding process that requires local governments to demonstrate that their request for more funding is based upon an increase in the number of mandated children, or that the treatment costs have increased due to the services needs of the children.

Because base allocations are often not sufficient to serve their mandated populations, many localities must request supplemental funds each year and present additional data to justify this request to the Office of Comprehensive Services (OCS). Thus, a key issue considered by the Steering Committee is whether a larger percent of dollars can be shifted from the supplemental pool into the initial base allocation without exposing the State to any undue fiduciary risk. It is expected that this policy change would greatly reduce the number of supplemental submissions, while providing better data to support more accurate program caseload and cost projections.

Recommendations

Near Term Action:

- Freeze supplemental funding at the FY 03 level and place any new dollars appropriated into the base allocation.

- Separate child specific data from the supplemental process with the understanding that the data collection will be addressed in some manner to increase the quantity of data provided to the state.

Long Term Action:

- Complete a systemic study of the allocation formula and consider creating an efficiency incentive related to the base allocation.

- Consider elimination of the local match for Medicaid cases. This is not feasible in the current fiscal climate.

The State Organization and Structure of CSA

Statement of the Problem

State-level management of CSA is predicated on the concept of inter-agency cooperation and local control. As a result, no one agency is responsible for the program's administration. Instead, CSA policy development, program management, and oversight responsibilities are vested with multiple agencies. Studies have shown that the benefits of this novel approach to management appear to be offset by the lack of attention given to the basic elements of program management. As the program has grown in size and complexity, this management structure does not appear to have yielded the stewardship needed to ensure the proper management of the program.

Recommendations

Near Term Action:

Develop a legislative package on State Structure to include the following changes.

- The State Executive Council (SEC) to be chaired by the SHHR or a designated Deputy SHHR (Presently, the chair is elected by the members of the SEC).
- The State and Local Advisory Team (SLAT) to be chaired by a local government representative(Currently, the chair is elected by the membership and focus is often State operations); to advise SEC on state agency policy and impact on localities.
- As with any state agency, dispute resolution is through SHHR and the Governor (Currently, the dispute resolution involves an informal review by OCS and a formal review by the SEC).

Strategies for Increasing Collection of Federal Reimbursement

Statement of the Problem

Funding for CSA is a state-local partnership. In FY 01, the local share averaged 37 percent. Since the inception of the program, CSA has been defined as the final funding source, to be used only after other resources (programmatic and fiscal) were explored. Use of other funding sources saves both state and local dollars. While many localities place considerable importance on locating alternative funding sources, others do not.

Recently, particular emphasis has been placed on exploration the use of Title IVE and Medicaid as additional funding sources for CSA. The Department of Social Services has reportedly simplified administrative requirements related to eligibility determination for Title IVE and provided training to local agencies. However, in terms of census and expenditures, Title IV-E foster care growth has not kept pace with growth in non-IV-E foster care.

In 1998, the General Assembly directed that two additional services -- treatment foster care and residential psychiatric services -- become Medicaid reimbursable. Still, since the addition of those services, Medicaid utilization patterns have been significantly below the level that was originally predicted. In view of the potential cost savings at the state and local level, more work is needed toward greater use federal funding sources available to replace state and or local funding.

Recommendations

Near Term Action

- Expand the scope of Medicaid coverage. Consideration will be given to additional levels of residential treatment; expansion of case management; elimination of the limit on Intensive In-Home Services accompanied by required review and reauthorization; reassessment of the current definition of "family" for Intensive In-Home Services. Additionally, FAMIS will be examined as an alternative funding source for some children normally served in CSA.

- Determine what barriers exist to impede local use of Title IV-E and determine if the scope of use can be expanded further.

- Continue and expand training for State and local agencies s related to the use of: EPSDT, Medicaid, and Title IVE.

Long Term Action

- Examine the feasibility of requiring CSA service providers to become Medicaid certified as a condition of participating in the CSA program.

Managing, Evaluating and Monitoring Care in CSA

Statement of the Problem

A hallmark of CSA is the significant authority vested with the local governments for the operation and management of the program. Studies conducted during the early years of CSA indicated the many localities were not implementing CSA according to legislative intent. Further, there was no uniformity in the assessment process for children, and only a small number of localities had formal utilization review programs. Since that time, CSA has required localities to use a uniform assessment instrument and participate in a utilization management (UM) process. Nonetheless, questions have surfaced about the degree and extent to which localities are using the State's uniform assessment instrument. In addition, the UM process has not won widespread acceptance among local governments and questions about the effectiveness of the program remain. Due to these factors and the absence of a comprehensive data system, the State has been unable to adequately assess the appropriateness and quality of care that children are receiving through the program.

Recommendations

Near Term Action:

- The OCS will facilitate the provision of additional utilization management training for localities, as well as training to support the proper use of the Child and Adolescent Functional Assessment Scale (CAFAS™) assessment instrument.

- Localities should continue using the (CAFAS™) uniform assessment instrument but with 8 versus 5 scales. This will require revision on the Levels of Need Chart, which contains guidelines for services/treatment. High Priority.

- A designee of the Secretary of Health and Human Resources will conduct an evaluation of the alternatives to the CAFAS™ uniform assessment instrument currently used in CSA, to include the Childhood Severity of Psychiatric Illness (CSPI) assessment instrument.

Managed Care As An Option For CSA

Statement of The Problem

While a number of the recommendations proffered in this report have the potential to slow the growth of CSA general fund expenditures, these proposed changes are unlikely to produce large-scale reductions in the cost of the program. As a result, a significant amount of interest has been expressed in the concept of managed care as a basis for curbing CSA expenditure growth. In the strictest sense, a statewide CSA managed care program would vest a third party -- typically a private corporation -- with the authority needed to manage the provision of mental health services to children in the program. With this arrangement, it its theorized that the sometimes wide and unexplained variations that occur in CSA expenditures can be reduced through greater control and management of the treatment planning and service delivery process for children.

Understandably, there are a number of concerns and questions about the appropriateness of the managed care model for CSA. For example, local agencies point out that they face clear statutory requirements for providing sum sufficient services to certain children in CSA. Any actions by managed care authorities to restrict treatment under these circumstances would, it is argued, be in obvious conflict with that authority. Efforts to eliminate this conflict would require that the legal responsibility for the care of these children be shifted to the private managed care entity – an untested and potentially risky strategy.

Despite these concerns, many familiar with the operation of CSA acknowledge that questions about the local management of CSA funded services, lingering concerns about the utilization review process, and the persistent cost increases in the program require that some aspects of managed care be given more consideration as a possible vehicle for reducing expenditures in the program.

Recommendation

<u>Long Term Action:</u>

- A designee of the Secretary of Health and Human Resources will lead a study of options existing in managed care technologies, which are appropriate to Virginia's system of care, to assist with the management of CSA.

Assessment and Development of Negotiated Statewide Contracts for Services Purchased by State and Local Agencies

Statement of the Problem

Currently, the Code of Virginia (§2.2-5214) requires that the "rates paid for services purchased pursuant to this chapter shall be determined by competition of the market place and by a process sufficiently flexible to ensure that family assessment and planning teams and providers can meet the needs of individual children and families referred to them." Both the Joint Legislative Audit and Review Commission's (JLARC) Review of CSA (1998) and the Department of Planning and Budget's (DPB) Review of the Budget for CSA (2000) noted the relationship of provider rates/local level negotiations and CSA costs. However, the ability of local CSA programs to negotiate the best rates possible for the services they purchase is impeded by bundled service rates. Moreover, both the service providers and local officials agree that the contracting process would be significantly improved if the State adopted standard contract language.

Recommendations

Near Term Action:

- Development of a standardized contract (by a diverse stakeholder group lead by the OCS) to be used statewide with allowance for addendums by individual localities.

- Provision for "unbundling" of services. This is to be done in conjunction with efforts to develop standardized contracting.

Long Term Action:

- On-going enhancement of Service Fee Directory (an electronic directory developed to assist providers in sharing information regarding services and fees) to enable localities to become informed purchasers of service. The directory is currently located on the CSA web site. High Priority.

Coordinated Collection Of Information Among State Agencies

Statement of the Problem:

There has been on going concern about the limited amount of data available on children served through CSA. The Office of Comprehensive Services (OCS) collects limited demographic data on the CSA population. A considerable amount of data exists on the children in CSA in various state and local agencies. However, these data are in both hard copy and electronic files. There is no consistency around the types of data that are automated. Further, the absence of unique identifiers for CSA cases, and the lack of compatibility across the various legacy systems make data sharing an expensive and technologically challenging proposition. Additionally, as will be discussed later, the lack of available data has complicated the task of projecting caseloads, service needs and costs for the program.

Recommendations

Near Term Action**:**

- Develop interim data reporting to expand quantity of data (but not data elements) that is currently collected by OCS. The expectation will be that data currently collected only on children involved in supplemental funding requests will now be submitted on all CSA children on a point in time basis. It is anticipated that reporting requirements will be combined to reduce state and local administrative burden. This project will be lead by the Office of Comprehensive Services in collaboration with technical experts and local governments.

Long Term Action:

- The Office of the Secretary of Health and Human Resources will take the lead in effort to further explore and resolve issues related to the establishment of an automated information system containing data on all children who receive CSA services. This will be an expansion of the project involving state agency MIS Directors and related to coordinated collection of information among state agencies.

Projections of Caseloads, Service Needs, and Costs

Statement of the Problem

While projections of caseload and costs have been accurate over the years, there has been a lack of sufficient advanced integrated data to justify an increased initial appropriation. As has been discussed, the range and type of program information collected from localities is quite narrow. This greatly limits the prospect of successful forecasting. The only reliable data available -- from CSA payment records -- cannot support more sophisticated statistical forecasting. The only data available for projecting expenditures is the record of aggregate annual expenditures and overall growth rates.

In light of these problems, one task group was charged with considering the data and trend analysis necessary to project caseloads, service needs and costs in a way that will enable public policy makers to be proactive in addressing the challenges in CSA. However, until such time as the data collection issue is resolved, any recommendations must be put aside for future consideration.

Recommendation

Long Term Action

- All work on forecasting should be held in abeyance until CSA information management needs are appropriately addressed. The chair of the task group that considered projections of caseloads, service needs and costs will be asked to serve as a resource to the group considering technical processes. In turn, DPB will be kept apprised of changes as they occur and be prepared to begin taking advantage of increased forecasting capabilities, particularly as improved data becomes available through the project discussed above, in conjunction with the six year financial plan.

Appendix A A Blueprint For Change In CSA			
Action	**Next Steps**	**Lead Responsibility**	**Expected Time Table**
Near Term-High Priority			
Freeze supplemental funding at the FY 03 level and place any new dollars appropriated into the base allocation.	Prepare budget amendment	OCS provide to DPB	Within DPB prescribed timeframes
Develop interim data reporting to expand quantity of data (but not data elements) that is currently collected by OCS. Will expect data currently collected to be submitted on all CSA children on a point in time basis. Will attempt to blend reporting requirements.	Work with technical experts and local representatives to develop the reporting methodology	OCS-Alan Saunders	End of the Third Quarter of FY 03
Upon the adoption of the above referenced interim data reporting process, separate child specific data from the supplemental process.	Following completion of the above action and provision of training to localities, discontinue current supplemental data reporting process.	OCS-Alan Saunders	By beginning of FY 04
Expand the scope of Medicaid coverage, to include examination of FAMIS.	SHHR to direct DMAS to consider expanded options recommended by the task group	DMAS-Cynthia Jones	Implementation of expanded coverage effective no later than January 1, 2004.
Determine what barriers exist to impede local use of Title IV-E and determine if the scope of use can be expanded further.	SHHR to direct DSS to consider barriers and potential areas for expansion	DSS-David Mitchell	Implementation of expanded coverage effective at the beginning of FY 04.
Coordinating state agencies training such as but not limited to: EPSDT, use of CAFAS in service planning, and negotiating with providers.	Utilizing the existing Training and Technical Assistance Group, develop and provide training that will meet local partners needs.	OCS-Alan Saunders	On-going

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Action	**Next Steps**	**Lead Responsibility**	**Expected Time Table**
State Structure changes: SEC to be chaired by SHHR or a designated Deputy Secretary; SEC to be visionary, futuristic; SLAT to be chaired by local government representative advisory to the SEC on state agency policy and impact on localities. ; as with any state agency, dispute resolution is through SHHR and the Governor.	Develop legislative package	SHHR	October 15th per budget language.
Development of a standardized provider contract to be used statewide with allowance for addendums by individual localities.	Assemble a group of diverse stakeholders	OCS-Alan Saunders	By the end of the Third Quarter in FY O3
Provide for "unbundling" of services.	To be done in conjunction or parallel effort with the item related to standardized contracting.	OCS-Alan Saunders	By the end of the Third Quarter in FY O3
Continue use of the CAFAS™ instrument with training noted above.	Notify localities of change to the 8 scale CAFAS.	OCS-Alan Saunders	On-going.
Evaluation of an alternative to the CAFAS™	Develop an evaluative process	SHHR Designee	Any changes implemented for the new biennium.
LONG TERM-HIGH PRIORITY			
Consider creating an efficiency incentive related to the base allocation.	Work with local representatives to complete a systemic study of the allocation formula	OCS-Alan Saunders	July 15, 2003

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Action	**Next Steps**	**Lead Responsibility**	**Expected Time Table**
Enhancement of Service Fee Directory to enable localities to become informed purchasers of service…link to licensing information.	Work with technical experts and local representatives to develop the necessary system changes	OCS-Alan Saunders	On-going
Expansion of the project related to coordinated collection of information among state agencies to further explore and resolve issues related to the technical processes.	Office of SHHR to form a group of experts to carry this project forward. It is anticipated that the group comprised primarily of state agency MIS Directors will continue with expanded membership.	SHHR Designee	Group will be assembled and have the first meeting by January 2003.
On-going review of forecasting capabilities, particularly as improved data becomes available through the project discussed above, in conjunction with the six year financial plan.	The chair of the task group that considered caseloads, service needs and costs will be asked to serve as a resource to the group considering technical processes. In turn, DPB can be kept apprised of changes as they occur.	DPB	Related to progress of above group.
Study of options existing in managed care technologies, which are appropriate to Virginia's system of care, to assist with the management of CSA. To include issues related to evaluation and monitoring.	Office of SHHR to form a group of experts to carry this project forward.	SHHR Designee	Group will be assembled and have the first meeting by November 2002.
LONG TERM-LOW PRIORITY			
Examine the feasibility of requiring CSA service providers to become Medicaid certified as a condition of participating in the CSA program.	Work with local representatives to develop the policy	OCS-Alan Saunders	On-going
Consider elimination of the local match for Medicaid cases.	Not feasible in this fiscal climate.	DPB	Re-examine for the new biennium